Working Group to Reinvent Medicaid
Optional Working Session
Wednesday June 24 2015
7:30am – Meeting Notes

Attendees: Ira Wilson, Peter Andruszkiewicz, Maria Montanaro, Michelle Brophy, Jennifer Wood, Rick Jacobsen, Beth Lange, Cheryl W, Patrice Cooper, Mark Peral, Tom Kane, Linda Katz, Holly Cekala, Bill McQuade, Secretary Roberts, Matt Trimble, Nicholas Oliver, Larry Ross, John Andrews, Garry Bliss, Jennifer Reid, Mike Cooley, Dennis Keefe, Debbie Morales, Matt Harvey, Sam Salganik, Chuck Jones, Paco Trilla, Elizabeth Burke Bryant [others joined post introduction period]

I. Welcome – Dennis Keefe: This is our last themed optional working group session. These have been well-attended, good conversations for deep enough dive to learn at these theme sessions. Later today we have the larger Working Group meeting to coalesce around what we have learned and integrate that into our phase 2 report. The goal continues to be to have the report ready for the governor by July 8.
Ira Wilson: Let's do quick introductions: [see attendees list noted above]

II. Quality Metrics and Measurement
   a. Adult Quality Metrics, Bill McQuade, EOHHS: Slides available on website reinventingmedicaid.ri.gov. Received the adult quality grant in December of 2012, with a no cost extension through December 2015. Questions and discussion that follow noted below:
      i. Dennis Keefe: On demographics, in race, ethnicity, can we drill down that far?
      Bill McQuade: Yes. I will say that in that category our race data has never been very good, but language spoken at home has been a good data set.
      ii. What is PDSA?
      Bill McQuade: Plan, Do, Study, Analyze.
      iii. Dennis Keefe: Going strictly with administrative measures to really pull this data out you are going to get in areas that through administrative measures it will be difficult to know what is going on and thus may go into chart orders?
      Bill McQuade: Right those are hybrid measures, if we get more resources then less of a pull on those. As we look at 30 different measures through administrative data hopefully we can identify enough problems with administrative data, follow up on that, and then use the hybrid measures for follow up.
      iv. Tom Kane: Is there a time frame for the DD population?
      Bill McQuade: Yes, we are putting together a data set now that hopefully will allow us to get in there hopefully by the end of the year.
      v. Linda Katz: Is there a list of the 15 measures?
      Bill McQuade: We can get that to you.

vi. Sam Salganik: You talk about wanting to stratify by provider, in RI there may be provider groups with not enough data?
Bill McQuade: That will be an issue when you want to look at it for the specific provider. Mathematical measures that apply well to a managed care entity. When you do a performance measure and make judgments about that plan, that makes sense, you add some variance when you go down to the practice site, as a patient isn't required to get all that care at one site. You may want to hold that practice responsible, but it gets wider when you look at individual physicians.

vii. Linda Katz: Is there anything that measures quality of experience from patient perspective?
Bill McQuade: Yes, pat of it is member satisfaction surveys and we are doing one for the FFS population in addition to those that the MCOs are doing.

viii. Matt Trimble: The team, the EOHHS team that does all this work, can you speak about that, how many etc.?
Bill McQuade: There are three, Noelle, Bill, Cheryl, Cara, we work closely with the analytics unit in Xerox and that team, and also work closely with Debbie Morales and quality improvement projects. That combines with our close work with project administrators across the agency.

b. Debbie Morales, EOHHS – Slides and accompanying docs available on website reinventingmedicaid.ri.gov. Questions and discussion that follow noted below:

i. Secretary Roberts: Are these requirements the federal government offers us?
Debbie Morales: It is definitely in our contract that we require health plans to be NCQA accredited, and feds require quality strategy.
Rick Jacobsen: We develop based on that quality strategy, and then the plans go from there, so an amalgamation.

ii. Elizabeth Lange: Many of the measures on the list are noted as pediatrics, but unsure how they bucket out. Can we put them into buckets?
Debbie Morales: Yes I can do that and have it put on the website.

iii. Director Montanaro: What are the performance incentives or penalties associated from this date from the plans in the contracts?
Debbie Morales: There are not currently penalties, there is a pool of dollars available each year to the plan, and each measure is allocated, weighted to those dollars.
Director Montanaro: What percent is that whole incentive pool to that overall participant?

Rick Jacobsen: A little less than one percent, but given the size that will work.

iv. Dennis Keefe: This is a very sophisticated group around the table, so we get the raw score and percentile range. Want to be sure we are chasing the right goals – may have a good raw score and low percentile ranking and want to balance it out. Just wanted to underscore that.

v. Rick Jacobsen: One comment on metrics when we first started this program in the late '90s we made up the measures. Somewhere in the interim measures the HEDIS data set began to become accepted. The emergence of standardized metrics gave us some comparison. We can look at Medicaid, we can look at commercial and Medicare advantage. Still now HEDIS is starting to creep a little bit as it is process measures and bulk of talk is about outcome measures. Just keep in mind.

vi. Ira Wilson: We tend to measure what as can measure and often there are things we should but do not measure. Most of these measures are Primary Care based or close to primary care based. Most of the numbers I have seen is what fraction of the budget is primary care vs. specialty care. One measure I think we should think about is access – Medicaid patients have trouble with timely access to specialty care. So you are not measuring the quality of the specialty care, is that a problem, is that worth thinking about? In the drive towards Primary Care Medical Homes (PCMH) and doing primary car right, we sometimes lost in the battle the fact that almost all the high utilizing patients require specialty care to be combined with primary care.

Chuck Jones: I will affirm that access to specialty care can be spotty depending on the specialty. They may be listed, but often we hear that they hit their RIte Care, so one of the other opportunities we talk about are tele-consults. The pay a small fee to the specialists, in advance of the patients showing up. Access is an area we are looking to.

Paco Trilla: I think nationally access is an issue perhaps less of an issue in the northeast than elsewhere in the country. In terms of the end of the NCQA on these medical plans, so to perform top ten on these plans these are not perfect and I think you are right if there is one big area of concern for most of the country is that specialty care access.

Director Montanaro: The next iteration of measures really have to drive some of those results in that high need high utilization population and that is not where HEDIS focused. This is where RI could lead the way, really trying to use the pay for performance systems and really drive measures across quality and outcomes. While access to specialty care is one thing, the

specialist role is within that management we are not doing well. In the BHDDH world we are focusing on that in our SMI group. Even without having broad based measures, we have started to drill down on these measures.
Peter Andruszkiewicz: HEDIS is state of the art as we know it today, but we all know it is far from perfect, need to move further upstream, to where the cost drives are where the outcome measures are. If there is a disconnect between our process measures and outcome measures that is an issue.
Elizabeth Lange: The numbers are really exciting, and it's good, but there are many ants under this ant hill. For the providers that make these numbers work, I am not sure what providers know what an accomplishment this is and if it were possible to send a thank you note it would not go unnoticed.
Dennis Keefe: The intersection between policy and the market is integral. Specialist networks within an ACO will be critical going forward, folding in behavioral health as well. I think access for specialists is on everyone's radar. One comment this is great information, but I am interested in the flow of the info to health plans and then to the provider community as I sense another disconnect there. Whether its public policy or modeling.
Secretary Roberts: I want to weigh in on another thing, in both we have talked about data and ranking some is about the linkage, that data and statistics isn't going to be valid. Want to be sure we are not only chasing rankings and stuff, but it is a huge quality and cost issue. Don't want to inappropriately stop doing one in favor of the other. In RI, some of our numbers are too small if chasing rankings.

vii. United: We have two clinical practice consultants working with those in the Medicaid department, not necessary individual provider but aggregate them by tax ID number with our plan results and the HEDIS measures. We also have a provider advisory committee as well, and to the point about a thank you note we do acknowledgements in our newsletter but we hear you. United has been sending communications around health plan specific rates, but ultimately that measure is more impactful if it includes the rates for neighborhood. Dovetailing with the work of the state and this grant is important.
Bill McQuade: Most HEDIS measures require 12 months of continuous enrollment to be included in the denominator. Even on the commercial side people are changing health plans more frequently than they used to, so keep that in mind. I want to say that about 60% of Medicaid members are continuously enrolled.
Rick Jacobsen: For RIte Care our churn is like 1.2 to 1

Matt Harvey: That may change though with the new eligibility system renewals are easier.

c. Jennifer Wood, EOHHS - SIM Harmonization measures.
Jennifer Wood: You have heard this morning about some of the very robust work done in Medicaid around devising measures, so this is all very much a work in progress and CMS is now pushing the states through environments. Many of the discussions we are having in recent days we know we could spend the next five years on this full time and not fully have arms around it and measurement is certainly one of those areas. The feds are pushing at the state level through SIM to take Medicaid Medicare and commercial payers and look at what we are measuring, why we are measuring and take that patchwork quilt. As of 5 years ago many commercial payers were using home grown measurement measures. Now in an environment in which want to use measurement for a variety of purposes and with providers at the beck of a plethora of requests, reporting the any masters for all of those. What we are learning as a part of the SIM engagement is that as we go beyond Medicaid to all payer, we need to develop core measures for RI that all can embrace for certain purposes. We had a great presentation last week with Michael Balitt who has done lots of work on this nationally. Two takeaways: hard work, detailed takes time to arrive at a destination. The second is that is has been done and can be done and in at least six states they have moved through a methodology in good detail of seventeen steps in a proves of an environment like we have in RI for why we are seeking to have some commonly held measures, and then digging into the measures themselves. Through SIM and the SIM steering committee, we are now fostering a work group specifically on measure harmonization that will go into the RFP for the project management to support the work of the SIM. Many of you or your organizations are already taking part in this but we will put out a general call on this to gather any who may be interested in participating to do so. Not necessarily measure devisers, but people who feed into measures, what we are collecting goes into a variety of quality measures not just pure payment. Other things being done in the SIM environment is the allure of measures. As you begin to discuss it in any room, what do you want to discuss and why, and what can we throw overboard to streamline. One of the key messages from the talk last week is having real discipline about what you need to know and what you want to know. Everyone has a pet measure that they like, but need to be focused. He also discussed measure creep. The notion that even HEDIS measures or good for national comparative reasons may not be valuable for us as a state. Two ends of bell curve, if already doing well on something it is important to be sure that doesn't erode, but that isn't necessarily the focus for collection, analysis and change. At the other end of the spectrum there may be gaping wounds that we are not addressing,

but similarly is that when you want to focus or collects as you may not have any evidence or ability to change that reality. The reason for collecting and measuring, needs to be focused needs to be the core work of the SIM team, and to what end, can the dial be moved if we have the info. From a policy perspectives, decisions need to be made. Across different populations, pediatric, gerontological there are different things to look at – but can you get to core measures and then custom for the set groups? Big decisions to be made at the policy level for an all payer like structure which is what the SIM is supporting. Part of what we have funding in the SIM to do is to explore the potential of a commonly held state platform for the submission of data around measures and the extraction of data around measures. That is only a twinkle in its parents' eyes in the application that we submitted, but part of the decision to make as a state is whether we stand up some sort of a plan as a web resource for the measure input and extraction – provided we come up with a harmonized measure set. The utilization of measurement will need to be developed across groups.

i. Ira Wilson: How does the APCD fit into the issue of shared infrastructure for submission extraction?
   Jennifer Wood: We have now access to all claims through APCD. Claims data has strengths and limitations, sheds light on certain things and not others. Right now it is the first layer of a cake in terms of a commonly held resource – a critical tool, but is it the end all and be all for what we need going forward in terms of utilization measures, probably not. Yet it is a big place we go to first as providing and implementing.
   Dennis Keefe: I would add the APCD is that as we all stand up for EMR, we need to look for progress. There may be room for automation in the future.
   Jennifer Wood: There have been many discussions about health records and ACPD connection in the far future.
ii. Director Montanaro: Measure harmonization cannot be measure modulation. Often as we look for measures that we all can agree on they become so generic. As plans partner with providers and the state, and partner with initiatives it creates demand to fish up stream and demand tools that will put care management at the point of care. My concern is that if we wait for an overarching structure we lose the opportunity to really look at how we can plug and play with some tools that are out there. From my provider experience solutions bubble up better when coming out of necessity rather than working towards one IT infrastructure that when finally built is outdated. Let the front runners run, do harmonize measures but guard against aspects that create that kind of harmonization. __: To that point, we spend a lot of time talking

about measures but we need to talk about methodology too.
Elizabeth Burke Bryant: The selection is key - the magic the communications power of individual indicators to tell you if things are going in the right direction. There are some core children's health measures going in the right direction. Some of those scores are important –even if we are head of the pact – to keep those going strong so that they don't become out of sight out of mind. Other indicators such as overweight/obesity, seem so obvious that we often forget about them. Need to really look at what we need, what are the cost drivers, what is the capacity, we are losing the ability to see what we are doing on something that is costing so much on our own. On those wish list indicators paring that with some of the cost driers and some selections, what are those need to be made in terms of health outcomes and cost drivers?
Jennifer Wood: There are certain kinds of public health indicators that are sacrosanct that will flow along regardless of other all payer indicators, and we do not want to conflate these two topics, as have a separate purpose to governing and governance. The SIM engagement is now to look at how we are buying healthcare and what we need to do that – so related and not distinct.

iii. Secretary Roberts: One of the things we have not done and could, is use the significant data that is reported to the department of health. We have a lot of ongoing measures there across payers and providers should look at those and see which of those we can link into our delivery system discussion.
Patrice Cooper: The health plans do work closely with DOH and agree. United is ready to launch ACOs, we have done it, we can do it. Population registry is a part of that, and while not nirvana, that is really the testing ground for us. We know that if we wait we wait too long.

iv. Matt Trimble: This is all very exciting but a lot of it seems to be 3, 4, and 5 years before being developed. This group put forth initiatives in which providers get funding back based on those incentives.
Secretary Roberts: I think to be honest we will start by working with the organizations that brought this to the table – national organizations, etc. who have been more focused on measurement. Will we get it perfect the first round, no? At the end of year one we can see what we got right, what we got wrong, looping in the national organizations. We are going to have focused implementation groups – developing implementation plans with implementation work groups. We are prioritizing based on how quickly we can move them through and complexity.

v. Peter Andruszkiewicz: I would argue we are getting what we have designed and a lot of it is good but it is not enough. I would agree with [Director Montanaro's] comment that it cannot be everything so that it doesn't die from its own weight. We understand, providers understand, what we want what are good things, what cost drivers are, what we want in terms of outcomes. That is where the state can sit down with providers – they know how to use the system today can help us to get to where we want to go.
Jennifer Wood: Some evidence to this, is based on the meetings we have had around this topic it is one of the most important topics to moving healthcare reform forward in RI. When we convene an informal workgroup to inform the steering committee, we were swarmed. Today we have a huge turnout – it means to us that this is what EOHHS needs to work with you all on and move forward. This really has folks' attention.
Dennis Keefe: I would say for CareNE this is one of our top ten priorities. Some process of rationalization would be extremely helpful, but I would also say that the marketplace waits for no one - if we have accountable structures and caring for a population based on risk, we need to develop what we have. Take the best on the public side, best on the private side and come up with a good merge of ideas. I wonder if nationally states have had success in this area, I know it is not a problem unique to RI.
Director Montanaro: Washington state has done a good job, other states NY and others are approaching it and finds an entry place. While the marketplace waits for no one, often it is led by public policy. We need to protect against things that can hang us up and the rest will follow.

vi. Ira Wilson: We need to stay focused that if there are not measures, or other important things, that we in small ways start developing means of measuring it. If quality care for chronic patients with may co-morbid disorders is missing and patients are suffering we need to look at it –let's take one or two and go from there. Start somewhere.

III. Public Comment: No additional comment made at this time.

IV. Adjourn: The chairs thanked everyone for their time and adjourned the meeting.